Mr. Chairman and members of the Committee, my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting AARP to testify on the need to strengthen Medicaid – a critical safety net for millions of our members and their families.

One in six Americans now relies on Medicaid – as declining income, reductions in the number of persons covered by employer health insurance and severely limited long term care options leave few alternative coverage sources. Enrollment growth, along with inflation throughout the health care system, is straining Medicaid as never before.

Clearly, some change is needed to alleviate the pressure on Medicaid and to make the program as effective as possible. But changes should be based on sound policies rather than an arbitrary budget target. We believe that $10 billion in Medicaid spending cuts could create serious barriers to care for beneficiaries.

For AARP, strengthening our nation's health care safety net is a priority, and we believe there are steps that Congress can take to relieve some of the strain within Medicaid itself.

- Significant savings can be achieved in drug spending through more accurate payments to pharmacies, greater rebates from manufacturers, the use of evidence-base formularies, and state purchasing pools.

- A broader range of long-term care options can be developed. Expanded home and community-based services – preferred by many older Americans – can be more efficient in many cases than nursing homes. Stronger consumer protections, such as ensuring premium stability, can make long-term care insurance policies more attractive to consumers. And outside of the reconciliation process, innovative financing methods – like enabling people to voluntarily use home equity for long-term care services – can be tested.

However, efforts to produce savings within Medicaid simply by shifting costs or denying necessary care will not hold down overall healthcare spending and will harm vulnerable populations.

- Efforts to prevent improper asset transfers should be properly focused on fraud, not the natural actions of typical middle class families. Changing the penalty date for Medicaid eligibility and extending the current look-back period to five years would deny needed coverage to individuals who simply helped family members or contributed to charities with no intention of gaming the system. These changes may result in severe hardship. Instead, state-based loopholes that allow abuses to occur should be closed.

- Options for long term care financing should not include changing the protected status of the American home.

- Increases in cost-sharing could create serious financial burdens for beneficiaries. Strong protections are necessary to help the most vulnerable.

- Increased "flexibility" in management should not include funding caps as they inevitably lead to denials of necessary care. Increased flexibility requires an open, thorough, and fair process for public input and ongoing assessment to ensure that changes do not cause harmful cost shifts or care denials.

Most importantly – it isn't enough to focus on Medicaid alone. Many of the problems facing the program are rooted in the lack of affordable coverage options outside Medicaid for both acute and especially long term care. The Census Bureau last week reported that fewer people received health care coverage from their employer in 2004 – down to 59.8 percent from 60.4 percent in 2003 – while the percentage covered by government health insurance programs rose from 26.6 percent to 27.2 percent. The number of Americans enrolled in Medicaid increased from 12.4 percent in 2003 to 12.9 percent in 2004.

Compounding the problem is spiraling inflation as we pay higher prices for new treatments without any direct comparative evidence that these treatments are better than less costly alternatives. According to many analysts, these rising costs are why more employers are dropping health coverage for workers, who in turn are seeking health coverage from Medicaid and other public programs.

Medicaid, despite its rising cost, still covers only three out of every five Americans under age 65 below the poverty line. An AARP survey this spring found that four out of five Americans oppose cutting Medicaid to reduce the federal debt, and a majority of respondents say their state does not have enough money for this vital program.

Avoiding Harmful Changes

AARP objects to some of the proposed Medicaid changes now being considered by Congress because they could result in cost shifts or denial of necessary care, rather than true increases in efficiency.

Preventing Improper Asset Transfers

There are legitimate concerns that some people who can afford long term care transfer assets to appear poor so Medicaid will pay for nursing home care. It clearly was not the intent of Congress that Medicaid be used this way, but with so few viable long term care options, estate planning attorneys have found many ways to do so legally. Loopholes in state laws – which vary from state to state – allow such abuses to occur. These state loopholes, including certain annuities and self-canceling installment notes, should be identified and closed.
However, some proposed changes now under consideration would hurt innocent people by denying them necessary coverage because of transfers that were in no way intended to game the system. These include:

- Changing the penalty date to deny coverage when people really need it. The current penalty date starts at the point a person makes an asset transfer. The penalty period lasts for as long as care could have been paid for by the amount transferred. For example, an individual who transfers assets equal to the cost of one year of care is ineligible for Medicaid coverage for one year from the date of the transfer. However, if the transfer occurred more than one year before applying for Medicaid, the penalty period is over and the individual is not denied coverage. The proposed change would start the penalty at the time of application for Medicaid, so if a person transfers enough to pay for one year of care at any time in the look-back period, the person would still be denied coverage for one year from the date of application, regardless of the need for coverage and lack of other financing options.

- Extending the "look-back" period for asset transfers beyond the current 3-year window to 5 years or more. Any asset transfer for less than fair market value, such as tithing to a church, donating to a charity and helping a grandchild pay college tuition, would be considered improper and result in denial of coverage, again regardless of the need for coverage and lack of other financing options.

Consider how these penalty date and look-back changes might affect a 66 year-old grandmother in good health who helps with her grandchild's tuition. Four years later, she has an unexpected stroke and requires nursing home care. Mounting health care bills force her to liquidate all her remaining assets. When those assets are exhausted, she applies for Medicaid but is denied because she helped her grandchild with college costs. She cannot go home, and has no way to pay for the care she needs.

Despite that kind of harm that would result, changing the look-back and penalty periods would do nothing to close real loopholes.

These changes would, instead, punish middle-income people for being caring parents and generous to their community. We should not deny needed coverage because someone tried to do the right thing in giving to a family member or charity long before an unexpected health care crisis consumed their resources and required nursing home care.

These changes are also unpopular with the American people. The survey we conducted earlier this year found that 75 percent of those surveyed oppose extending the look-back period. That is because the public knows that many people end up relying on Medicaid, not because they try to game the system, but because there are so few other affordable options for funding long term care. AARP believes it would be wrong to deny coverage to innocent people who need it when so little has been done to provide other affordable options for financing long term care.

Required Use of Home Equity/Reverse Mortgages

Some recent proposals have suggested that the protected status of the home be removed for Medicaid eligibility. These proposals would require older homeowners to use their home equity, such as by taking out reverse mortgages, before becoming eligible for Medicaid benefits. While using home equity to finance long term care may be a good option for some people, AARP strongly opposes proposals to *require* older homeowners to use their home equity to pay for long-term care or medical expenses in order to be eligible for Medicaid.

Home ownership is part of the American dream, a source of pride and economic security for most older people. Americans should not be forced to forfeit their homes to secure the care they need. Further, exhausting home equity could jeopardize the spousal impoverishment protections in current law and leave the community spouse – who may also need care one day – more vulnerable.

Reverse mortgages are costly, and mandating reverse mortgages would do nothing to reduce the high costs of these loans. These costs can amount to a very high percentage of the equity potentially available, especially for older homeowners with modest home values who are most likely to need Medicaid.

AARP believes that any use of home equity or reverse mortgages should be voluntary, should focus on reducing reverse mortgage costs, and be done on a demonstration basis to measure the effects before launching major changes.

Increased Cost-Sharing

We have serious concerns about proposals to make very poor people pay premiums and higher copays for the health care they need. Several studies demonstrate that imposing even moderately higher cost sharing on people with very low incomes results in them not getting needed care. They end up needing more expensive health care services, such as preventable emergency room visits and hospitalizations. There are no real savings in the long run but there exists potential for harm in the process. Because many beneficiaries require multiple health care services, even small increases in cost sharing requirements can very quickly add up to create significant barriers to necessary care. Any change that allowed states to increase cost sharing would need to limit the total amount beneficiaries would be expected to pay. Most importantly, the current Medicaid policy of not denying care to someone who cannot pay should be maintained for those who can demonstrate genuine hardship.

Increased Flexibility

A number of reform proposals have been described as mechanisms to increase program “flexibility” – a word that is very appealing and even more ambiguous. Some proposals labeled as “flexibility” are clearly harmful because they would inevitably lead to cost shifting and denial of necessary care.

These include any proposals that would place caps on federal funding to states through block grants, per capita caps, or some other type of allotment. AARP is unequivocally opposed to such proposals.

Other "flexibility" proposals may – if done right – improve program efficiency, for example by tailoring benefits to the needs of specific patient populations without denying coverage for medically necessary services. AARP therefore believes any proposals for increased flexibility need to be carefully, individually, and openly evaluated to determine whether they are likely to lead to true increased efficiency, or merely result in cost shifts and denial of care. Thus, any proposals for increased flexibility need to include meaningful opportunity for public review and input at both the federal and state level. It is essential that all stakeholders be allowed to review and comment on proposed policy changes, and that there be thorough and objective analysis of whether the changes could compromise beneficiaries' access to appropriate care. This is a serious concern, as current avenues for flexibility within the program lack adequate openness, or "sunshine."

Large-scale program changes are now allowed through a waiver process that is a cumbersome black box, with details negotiated behind closed doors between only state and federal officials. Some states have recently enacted laws, with strong support from AARP, requiring public hearings and other legislative review of waiver proposals before they can be enacted. However, in many states, only the most cursory attempt is made to adhere to requirements for public input.

There are even fewer opportunities for meaningful public input on smaller scale changes made through the state plan amendment process. Federal regulations merely require that a state publish notice of such changes before they are enacted along with an address to which comments may be sent. However, a state can enact such changes in as little as one day after publishing them and there is no requirement that submitted comments be acknowledged or addressed, often rendering the comment process virtually meaningless.

AARP urges Congress to require meaningful opportunities for public input – including hearings and written responses to stakeholder comments – before permitting policy changes that might be allowed under the rubric of "flexibility."

Relieving Pressures Within Medicaid

AARP supports steps that can be taken now to relieve some of the financial pressures on Medicaid in ways that make the program more effective. That is a critical distinction because, as discussed above, many proposals for reducing Medicaid expenditures would merely result in cost shifting and denial of care – not true efficiencies – and not really save money in the long run.

Overpayments for Drugs

The greatest potential area of increased efficiency is in payments for prescription drugs. AARP believes the following steps should be taken:

- Accurate Reimbursement to Pharmacies – Most state Medicaid programs now reimburse pharmacies based on the average wholesale price (AWP), a highly inaccurate and inflated measure of what pharmacists actually pay to obtain drugs. AARP believes Congress should require states to use a more accurate measure that is based on actual audited information on the cost to acquire drugs, such as average sales price (ASP) or average manufacturer price (AMP). In order to ensure fair margins for pharmacists, payments based on such a measure should include an adequate dispensing fee that fully covers legitimate overhead costs involved in filling each prescription.

- Increased Rebates from Manufacturers – Drug manufacturers are required to give rebates to states for Medicaid drug purchases, but studies by the HHS Inspector General indicate that the rebates paid by manufacturers are often much less than what is required. AARP believes the minimum rebate amount should be increased and steps taken to ensure full compliance with rebate requirements.

- Evidence-based Formularies – Some states are providing preferred coverage for certain drugs in each therapeutic class based on scientific evidence of effectiveness. If a drug is more expensive but not more effective than other drugs in its class, then it is covered only when a treating physician demonstrates that it is medically necessary for an individual patient. This yields significant savings by increasing use of the most appropriate drug – often a generic or other low-cost drug – while maintaining a safety valve for the small number of patients who truly need more expensive alternatives. States should be given strong incentives to use evidence-based formularies.

  Perhaps the most important step Congress can take to help states increase use of evidence-based formularies is to increase funding for "comparative effectiveness" research. This is needed to fill significant gaps in scientific evidence on which drugs are the most effective. Comparative effectiveness research can show whether a more expensive drug produces better outcomes and therefore is worth the cost, and when a less costly drug is as or more effective. The Medicare Modernization Act included authorization for comparative effectiveness research coordinated by the Agency for Healthcare Research and Quality (AHRQ) but to date the appropriations have fallen well below the authorized level.

- Purchasing Pools – Some states have joined together to negotiate collectively on behalf of all their Medicaid beneficiaries for increased manufacturer rebates, which can yield savings because the states are collectively negotiating for a larger number of consumers. States should be encouraged to participate in these pools and to add additional groups for whom they buy drugs, such as state employees and prison inmates, to further increase negotiating leverage.

Ending the "Institutional Bias"

Another potential area for increased efficiency is in providing more access to home and community based care as an alternative to nursing homes for long term care. AARP members strongly prefer to remain in their own homes. In many cases care provided in the home or community-based settings can help delay the need for more costly institutional services.

Medicaid, however, has an "institutional bias," that requires states to cover unlimited nursing home services when people qualify for them but makes home and community-based services optional. When home and community-based services are provided through federal "waivers," there are sometimes long waiting lists of people with legitimate needs who are denied coverage because the waivers cap funding. AARP supports efforts, such as the administration's New Freedom Initiative, to address this bias, and we urge Congress to make such changes a priority in any Medicaid reform package.

Affordable Long-Term Care Options

AARP believes that another way to alleviate some of the current pressure on Medicaid is to provide more options for financing long-term care needs. We hear from our members every day who are trying to do the right thing – balancing the demands of work and family and balancing their personal finances – while worrying about their future retirement income and how to pay for long-term care.

Unfortunately, there is no comprehensive public system of long-term care available to most Americans. Long-term care insurance is limited and generally expensive. Medicare covers very little long-term care, and Medicaid requires impoverishment before it will help – an all-too-often reality as paying out of pocket for long-term care quickly outstrips most people's personal savings. As outlined in AARP testimony before this Committee last April, we believe that options for expanded long-term care coverage could include:

- Reverse Mortgages*:* These allow people to voluntarily tap into the equity in their homes to fund a variety of options, including those that can keep people out of institutions and in their homes where they prefer to stay.

- Long term care Insurance*:* Currently long-term care insurance pays for only about 11 percent of all long-term care costs. Standards and protections for long-term care policies could encourage more consumers to buy such policies. For example, automatic compound inflation protection is needed to ensure that the value of the insurance benefits does not erode over time. And premium rate stabilization is needed to protect consumers from unreasonable rate increases that could make their policies unaffordable.

- Long Term Care Partnerships*:* These programs, which now operate in four states, are intended to promote long term care insurance by allowing purchasers to protect a certain amount of their assets and become eligible for Medicaid when the insurance benefit expires. While it is difficult to determine yet whether these programs have helped reduce reliance on Medicaid, they might offer another option for financing long-term care if several improvements could be made. These include:

    - Protecting Medicaid for low-income people if Partnerships increase Medicaid expenditures for those with significant assets.
    - Mandating consumer protections and clear disclosure of current Medicaid income criteria and the state's right to change them.
    - Guaranteeing the types of care (particularly home- and community-based services) that the state would provide under Medicaid.
    - Requiring that states monitor nursing home admissions to ensure that equal access is available to everyone, regardless of source of payments.

Conclusion

Millions of Americans rely on Medicaid's safety net. While some change is needed to make the program as effective as possible, we should reject those changes that simply shift costs or deny needed care to vulnerable populations.

AARP stands ready to work with Members of Congress on both sides of the aisle to enact policy changes that will strengthen this critical health care program for our most vulnerable citizens and to address the larger health care system shortcomings that are putting so much strain on this critical safety net.